

A million and  
of experience...

## Give or take a billion

You've had more experience with Dalmane (flurazepam HCl/Roche) than with any other benzodiazepine hypnotic... 15 years' worth.

You know you can *count* on it for sleep that satisfies patients - they fall asleep quickly and sleep through the night.<sup>1,8</sup> And the wide margin of safety with Dalmane<sup>®</sup> satisfies *you*. As always, caution patients about driving or drinking alcohol.





1 nights

**DALMANE**<sup>®</sup>  
flurazepam HCl/Roche<sup>®</sup>  
**sleep that satisfies**

Please see following page for references and summary of product information

**References:** 1. Kales J, et al: *Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. 2. Kales A, et al: *Clin Pharmacol Ther* 18:356-363, Sep 1975. 3. Kales A, et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 4. Kales A, et al: *Clin Pharmacol Ther* 32:781-788, Dec 1982. 5. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 6. Dement WC, et al: *Behav Med*, pp. 25-31, Oct 1978. 7. Kales A, Kales JD: *J Clin Psychopharmacol* 3:140-150, Apr 1983. 8. Tennant FS, et al: Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. 9. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977.

**DALMANE®**  
flurazepam HCl/Roche®  
**sleep that satisfies**  
15-mg/30-mg capsules



Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

**Contraindications:** Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported; abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

**Precautions:** In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

**Dosage:** Individualize for maximum beneficial effect.

**Adults:** 30 mg usual dosage; 15 mg may suffice in some patients. **Elderly or debilitated patients:** 15 mg recommended initially until response is determined.

**Supplied:** Capsules containing 15 mg or 30 mg flurazepam HCl.



Roche Products Inc.  
Manati, Puerto Rico 00701

Peralta Hospital Presents

## CANCER UPDATE 1986

A Clinical Approach to the Management of  
Common Malignancies

Non-Hodgkin's Lymphomas—Cancer of the  
Breast—Current Updates in Oncology

Friday, January 24 and Saturday, January 25, 1986

Merritt Peralta Health Education Center  
400 Hawthorne Avenue  
Oakland, California

CANCER UPDATE 1986 is a one and one-half day, no fee seminar sponsored by Peralta Hospital and the Medical Staff. Nine hours of formal Category I credit offered. Preregistration advised.

Call or write for registration information.

Education Department  
Peralta Hospital  
P.O. Box 23010  
Oakland, CA 94623  
(415) 451-4900, ext. 2327

## The Western Journal of Medicine

(ISSN 0093-0415/USPS 084 480) is published monthly for \$20 per year (USA and Canada) by the California Medical Association, P.O. Box 7602, San Francisco, CA 94120-7602. Second-class postage paid at San Francisco, CA and additional mailing offices.

**POSTMASTER:** Send address changes to *The Western Journal of Medicine*, Circulation, P.O. Box 7602, San Francisco, CA 94120-7602.

## Moving?

Please give us six weeks notice and supply your personal reference number.

ID No.

The Western Journal of Medicine  
P.O. Box 7602  
San Francisco, CA 94120-7602.

302703 XX

## The Western Journal of Medicine

P.O. Box 7602, San Francisco, CA 94120-7602



## **CNA has a longstanding commitment to your insurance needs.**

The CNA Insurance Companies' commitment to physicians began 15 years ago with quality malpractice insurance. Throughout the years, we have kept our commitment by providing malpractice protection, *without interruption*, even through the years of malpractice crises.

A major factor in our ability to provide this continuous insurance protection is our financial strength: CNA has more than \$12 billion in assets and \$1.1 billion in equity. With our financial strength, we can protect you not just today, but whenever you may need us. By providing liability insurance for thousands of medical professionals, we've gained solid expertise in underwriting, claims service and legal defense.

We'll continue our longstanding commitment to meet your needs.  
Contact CNA today.

CNA Insurance Companies  
Professional Liability Division  
CNA Plaza  
Chicago, IL 60685  
(312) 822-2229



The MGMA/AGPA-endorsed Medical Group Practice Program is underwritten by Continental Casualty Company, one of the CNA Insurance Companies.



For All the Commitments You Make®

# DRS. MILLER, BETTS, AND MCKAY GENERALLY AGREE ON MOST THINGS...UNTIL THEY DECIDED TO BUY A COMPUTER SYSTEM.

**D**r. Miller considered performance first and foremost. He wanted his money's worth. So he insisted on a system that would improve office efficiency, billing, collections, claims reimbursement... and also help with their marketing efforts.

Dr. Betts knew from experience that reliable hardware made by a reputable manufacturer was the only way to go. The group practice she recently left had outgrown their computer within a year and was plagued by constant malfunctions.

Dr. McKay's biggest concern was the vendor behind the system. He wanted to avoid the mistake his brother-in-law made when he bought his medical computer. Inadequate training, poor support and

service left his staff helpless. When the vendor finally went out of business, he was left with a very expensive orphan.

They did agree on one thing — price. Under \$20,000.

They found their solution. The Ledger Solution from Poorman-Douglas.

Dr. Miller was most impressed with the system demonstration. He especially liked it when the P-D representative showed how the system could actually provide a return on their investment.

Dr. Betts was satisfied to learn the The Ledger Solution operates on IBM or Texas Instruments hardware and that it can be expanded as their practice grows.

Dr. McKay was convinced after

calling several P-D clients. Training, service, and support rated excellent with every office. Going with a company that had served physicians for more than 25 years was icing on the cake.

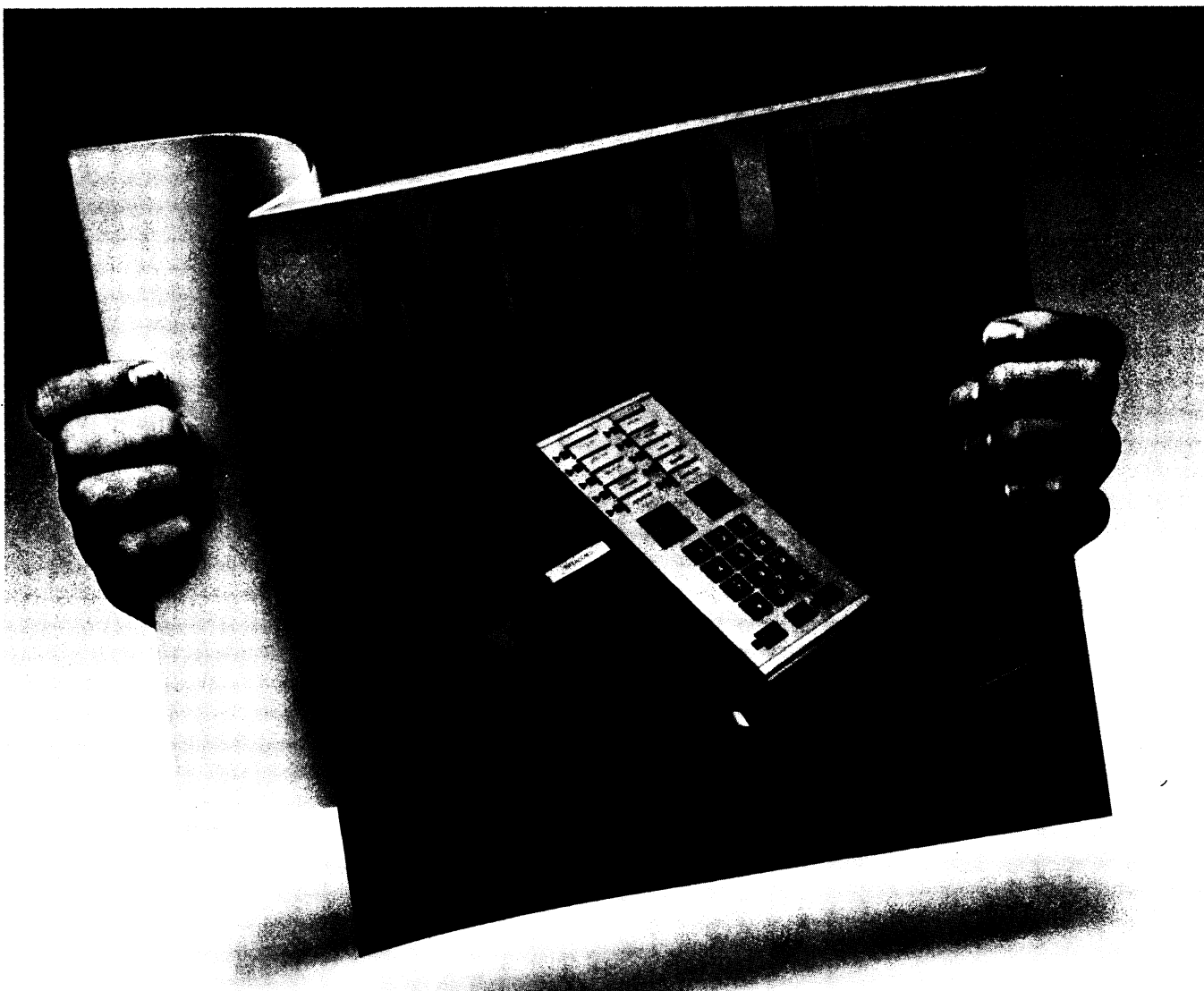
Call or write today for more information or a free consultation.



1-800-547-4407  
**POORMAN-DOUGLAS  
CORPORATION**

1325 SW Custer Dr., Portland, OR 97219





## IF YOU DON'T THINK A PHONE SYSTEM CAN MAKE A BIG DIFFERENCE IN YOUR SMALL BUSINESS, THIS FREE BROCHURE WILL SURPRISE YOU.

What you save in time and money may even astonish you. The MERLIN™ Communications System from AT&T memorizes your most important numbers for fast one-touch dialing. It remembers to redial your last busy number. It sets up conference calls, provides an intercom, pages and even grows as your business grows.

With the MERLIN System, you can customize each phone to meet the needs of each employee. Just select the features you want, and with a flick of a switch, they're programmed. And you

can add new capabilities to the entire system as you need them.



This "800" number automatically connects you to the office in your area.

Or mail to:  
AT&T Information Systems  
P.O. Box 45038  
Jacksonville, FL 32232-9974

Name \_\_\_\_\_  
Phone \_\_\_\_\_  
Company \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

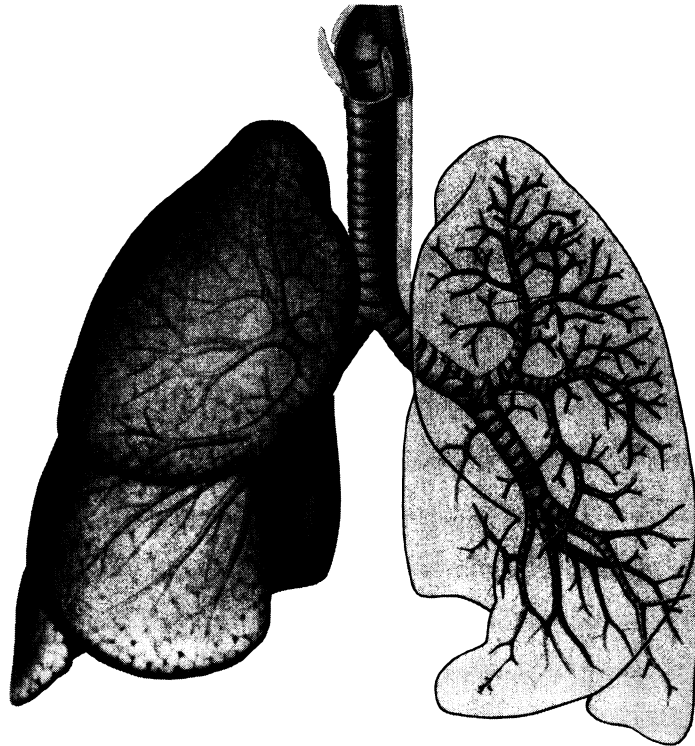
Call the Small Business Connection of AT&T Information Systems for our free brochure and find out why the MERLIN System is right for you. It's affordable, reliable and made especially for small business by AT&T.



**AT&T**

The right choice.

# Consider the causative organisms...



## Ceclor<sup>®</sup> cefactor

### 250-mg Pulvules<sup>®</sup> t.i.d.

**offers effectiveness against  
the major causes of bacterial bronchitis**  
***H. influenzae*, *H. influenzae*, *S. pneumoniae*, *S. pyogenes***  
(ampicillin-susceptible) (ampicillin-resistant)

**Brief Summary.** Consult the package literature for prescribing information.

**Indications and Usage:** Ceclor<sup>®</sup> (cefactor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

**Lower respiratory infections**, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

**Contraindications:** Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, manage-

ment should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

**Precautions:** General Precautions — If an allergic reaction to Ceclor<sup>®</sup> (cefactor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids. Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest<sup>®</sup> tablets but not with Tes-Tape<sup>®</sup> (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

**Usage in Pregnancy —** Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum

human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor<sup>®</sup> (cefactor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**Nursing Mothers** — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

**Usage in Children** — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

**Adverse Reactions:** Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

**Gastrointestinal symptoms** occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

**Hypersensitivity reactions** have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have

occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

**Causal Relationship Uncertain** — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

**Hepatic** — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

**Hematopoietic** — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

**Renal** — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

**Note:** Ceclor<sup>®</sup> (cefactor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

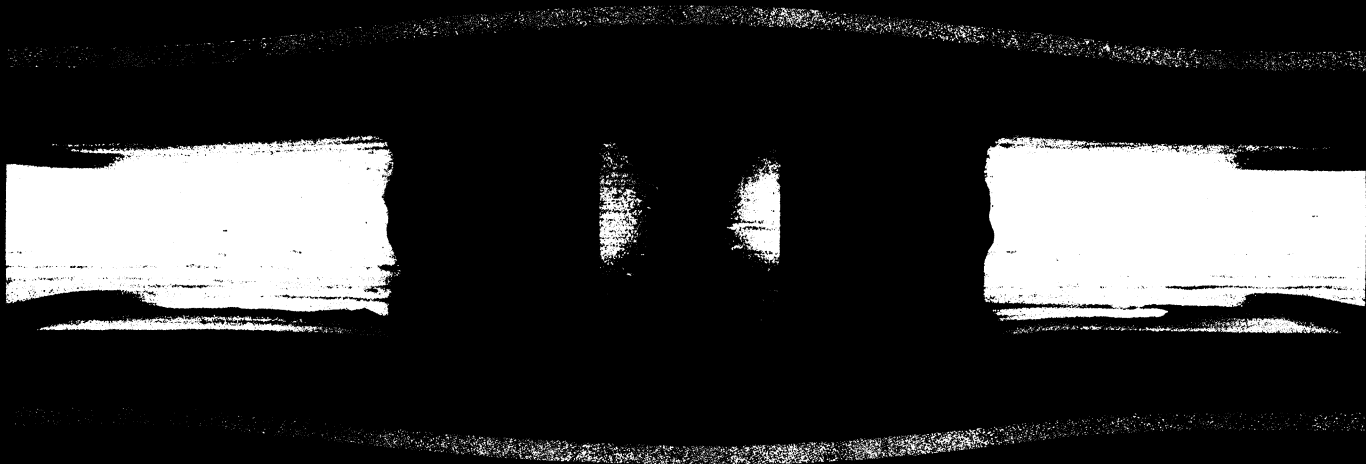
Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

© 1984, ELLI LILLY AND COMPANY

Additional information available to the profession on request from  
Eli Lilly and Company,  
Indianapolis, Indiana 46205.  
Eli Lilly Industries, Inc.,  
Carolina, Puerto Rico 00630



42041



***Start one-a-day***

***For full  
anti-  
arthritic  
action***



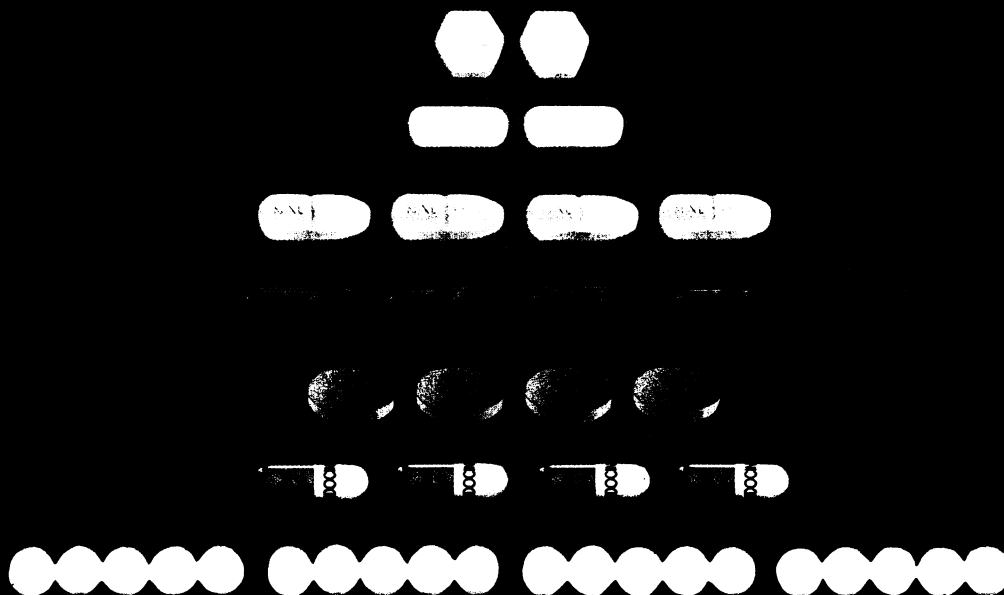
**NOW ON Medi-Cal**



**Start one-a-day**

**For full  
anti-  
arthritic  
action**

*One-a-day*



# SOUTHERN CALIFORNIA ORTHOPEDIC SURGEON

**Rapidly growing staff model HMO requires Board Certified (or eligible) Orthopedic Surgeon for Los Angeles/Orange County facility.**

**General Med provides a professional environment and excellent benefits including employer paid vacation time, CME time, malpractice and pension plan.**

**Convenient southern California location is within thirty minutes of beaches, mountains and beautiful Palm Springs.**

**Please send CV to:**

**Nancy Boostrom  
General Med  
2121 Towne Centre Place  
Suite 200  
Anaheim, CA 92806**

*Selecting a  
Health Plan*



*Weighing the  
Alternatives*

CMA CALIFORNIA MEDICAL ASSOCIATION

## Selecting a Health Plan

### —WEIGHING THE ALTERNATIVES

A new 16-page brochure, developed by the California Medical Association, provides basic information about health care coverage. Discussions include: group vs. individual plans; first-dollar coverage, co-insurance and deductibles; types of benefits; hospital income plans, specific disease coverage and "gap" plans; health maintenance organizations; and preferred or exclusive provider organizations. The booklet is a valuable resource for patients faced with an increasingly complicated, competitive medical marketplace. Copies are suitable for placement in waiting areas.

**Please send one sample copy**

- |   |  |
|---|--|
| <input type="checkbox"/> CMA members (enclose self-addressed, stamped envelope) | <input type="checkbox"/> 250 copies/\$40.00    |
| <input type="checkbox"/> Others (enclose \$1 per copy)                          | <input type="checkbox"/> 500 copies/\$70.00    |
| <input type="checkbox"/> 50 copies/\$12.50                                      | <input type="checkbox"/> 1,000 copies/\$125.00 |
| <input type="checkbox"/> 100 copies/\$20.00                                     |  |

Name \_\_\_\_\_

Address \_\_\_\_\_

State/Zip \_\_\_\_\_

Remittance must accompany all orders.

Make checks payable to:

Sutter Publications, Inc., 44 Gough Street,  
San Francisco, CA 94103-1233

# SORBITRATE<sup>®</sup>

## (ISOSORBIDE DINITRATE)

**Please consult full prescribing information before use. A summary follows:**

**INDICATIONS AND USAGE:** SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks. Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis.

**CONTRAINDICATIONS:** SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

**WARNINGS:** The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established. If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

**PRECAUTIONS:** **General:** Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE. The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy.

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary.

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur. Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory. The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined. However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals. On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months.

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers. In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly.

**Information for Patients:** Headache may occur during initial therapy with SORBITRATE. Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use.

**Drug Interactions:** Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle; therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug. A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet.

**Pregnancy Category C:** Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose. There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

**Pediatric Use:** The safety and effectiveness of SORBITRATE in children has not been established.

**ADVERSE REACTIONS:** Adverse reactions, particularly headache and hypotension, are dose-related. In clinical trials at various doses, the following have been observed:

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent. Cutaneous vasodilation with flushing may occur. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur. Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

**DOSEAGE AND ADMINISTRATION:** For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg; for oral (swallowed) tablets, 5 to 20 mg; and for controlled-release forms, 40 mg.

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose. In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure.

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours. Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported.

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended. The extent to which development of tolerance should modify the dosage program has not been defined. *The oral controlled-release forms of isosorbide dinitrate should not be chewed.*

**DOSEAGE FORMS AVAILABLE:** Sublingual Tablets (2.5, 5, 10 mg); Chewable Tablets (5, 10 mg); Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg).



**STUART PHARMACEUTICALS**

Division of ICI Americas Inc.  
Wilmington, DE 19897

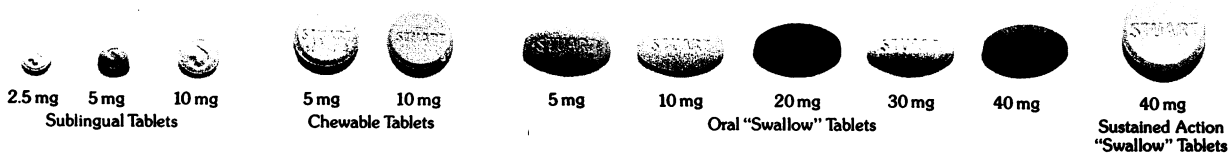
See following page.

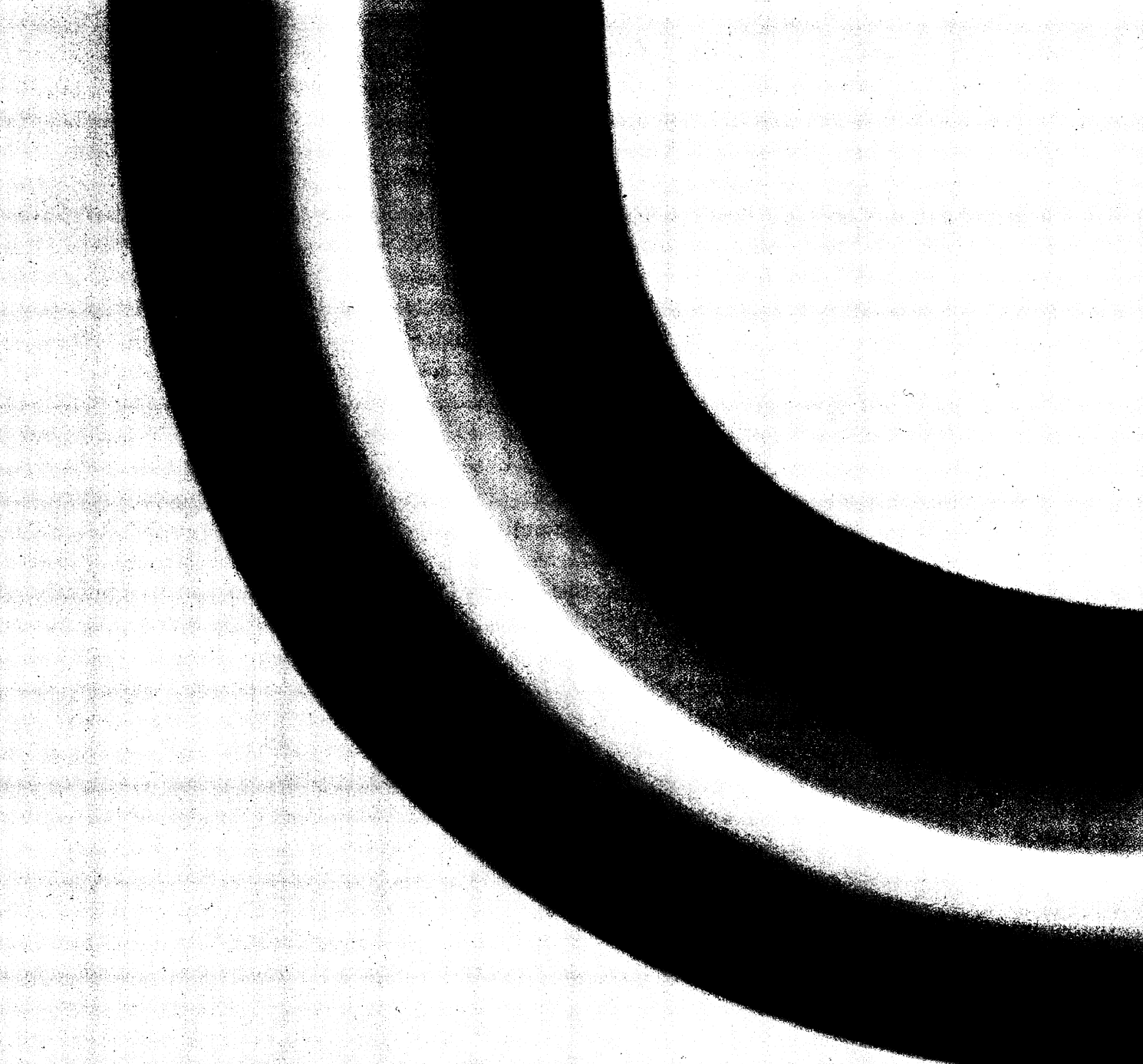
**Angina comes in  
many forms...**



**So does**  
**SORBITRATE®**  
(ISOSORBIDE DINITRATE)

**Unsurpassed flexibility  
in nitrate therapy.**





“With [CAPOTEN® (captopril tablets)]  
it appears that for the first time ever a  
patient can feel as well on treatment for  
high blood pressure as he does off it.”<sup>1</sup>

\*Angiotensin Converting Enzyme

†CAPOTEN may be used as initial therapy only for patients with normal renal function in whom the risk of neutropenia/agranulocytosis is relatively low (1 out of over 8,600 in clinical trials). Use special precautions in patients with impaired renal function, collagen vascular disorders, or those exposed to other drugs known to affect the white cells or immune response. Evaluation of hypertensives should always include assessment of renal function. See INDICATIONS, WARNINGS, and ADVERSE REACTIONS in the brief summary on the adjacent page.

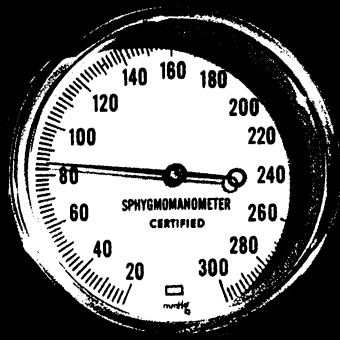
‡The most frequently occurring adverse reactions are skin rash and taste alteration; both effects are generally mild, reversible, or self-limited.

**Reference:**

1. Stumpe KO, Overlack A, Kolloch R, et al: Long-term efficacy of angiotensin-converting-enzyme inhibition with captopril in mild-to-moderate essential hypertension. Br J Clin Pharmacol 14(suppl 2):121S-126S, 1982.

New Prescribing Freedom—  
Mild-to-Moderate Hypertension

# Capoten Now for All Degrees of Hypertension



- ☐ Now for initial therapy of hypertension†
- ☐ Effective alone or in combination with diuretics
- ☐ Fatigue, loss of libido, impotence, and mental impairment almost never occur‡
- ☐ Convenient bid dosage

ACE\*INHIBITOR  
**CAPOTEN**®  
*captopril tablets*

HELP PUT QUALITY BACK INTO LIVING



## CAPOTEN® TABLETS Captopril Tablets

**INDICATIONS: Hypertension**—CAPOTEN (captopril) is indicated for the treatment of hypertension. Consideration should be given to the risk of neutropenia/agranulocytosis (see WARNINGS). CAPOTEN may be used as initial therapy for patients with normal renal function, in whom the risk is relatively low. In patients with impaired renal function, particularly those with collagen vascular disease, captopril should be reserved for those who have either developed unacceptable side effects on other drugs, or have failed to respond satisfactorily to drug combinations. CAPOTEN is effective alone and in combination with other antihypertensive agents, especially thiazide-type diuretics.

**Heart Failure:** CAPOTEN (captopril) is indicated in patients with heart failure who have not responded adequately to or cannot be controlled by conventional diuretic and digitalis therapy. CAPOTEN is to be used with diuretics and digitalis.

**WARNINGS: Neutropenia/Agranulocytosis**—Neutropenia ( $<1000/\text{mm}^3$ ) with myeloid hypoplasia has resulted from use of captopril. About half of the neutropenic patients developed systemic or oral cavity infections or other features of the syndrome of agranulocytosis. The risk of neutropenia is dependent on the clinical status of the patient:

In clinical trials in patients with hypertension who have normal renal function (serum creatinine  $<1.6 \text{ mg/dL}$  and no collagen disease), neutropenia has been seen in one patient out of over 8,600 exposed. In patients with some degree of renal failure (serum creatinine at least  $1.6 \text{ mg/dL}$ ) but no collagen vascular disease, the risk in clinical trials was about 1 per 500. Doses were relatively high in these patients, particularly in view of their diminished renal function. In patients with collagen vascular diseases (e.g., systemic lupus erythematosus, scleroderma) and impaired renal function, neutropenia occurred in 3.7% of patients in clinical trials. While none of the over 750 patients in formal clinical trials of heart failure developed neutropenia, it has occurred during subsequent clinical experience. Of reported cases, about half had serum creatinine  $\geq 1.6 \text{ mg/dL}$  and more than 75% received procainamide. In heart failure, it appears that the same risk factors for neutropenia are present.

Neutropenia has appeared within 3 months after starting therapy, associated with myeloid hypoplasia and frequently accompanied by erythroid hypoplasia and decreased numbers of megakaryocytes (e.g., hypoplastic bone marrow and pancytopenia); anemia and thrombocytopenia were sometimes seen. Neutrophils generally returned to normal in about 2 weeks after captopril was discontinued, and serious infections were limited to clinically complex patients. About 13% of the cases of neutropenia have ended fatally, but almost all fatalities were in patients with serious illness, having collagen vascular disease, renal failure, heart failure or immunosuppressant therapy, or a combination of these complicating factors.

**Evaluation of the hypertensive or heart failure patient should always include assessment of renal function.** If captopril is used in patients with impaired renal function, white blood cell and differential counts should be evaluated prior to starting treatment and at approximately 2-week intervals for about 3 months, then periodically. In patients with collagen vascular disease or who are exposed to other drugs known to affect the white cells or immune response, particularly when there is impaired renal function, captopril should be used only after an assessment of benefit and risk, and then with caution. All patients treated with captopril should be told to report any signs of infection (e.g., sore throat, fever); if infection is suspected, perform counts without delay. Since discontinuation of captopril and other drugs has generally led to prompt return of the white count to normal, upon confirmation of neutropenia (neutrophil count  $<1000/\text{mm}^3$ ) withdraw captopril and closely follow the patient's course.

**Proteinuria**—Total urinary proteins  $>1 \text{ g/day}$  were seen in about 0.7% of patients on captopril. About 90% of affected patients had evidence of prior renal disease or received high doses ( $>150 \text{ mg/day}$ ), or both. The nephrotic syndrome occurred in about one-fifth of proteinuric patients. In most cases, proteinuria subsided or cleared within 6 months whether or not captopril was continued. The BUN and creatinine were seldom altered in proteinuric patients. Since most cases of proteinuria occurred by the 8th month of therapy, patients with prior renal disease or those receiving captopril at doses  $>150 \text{ mg/day}$  should have urinary protein estimates (dip-stick on 1st morning urine) before therapy, and periodically thereafter.

**Hypotension**—Excessive hypotension was rarely seen in hypertensive patients but is a possibility in severely salt/volume-depleted persons such as those treated vigorously with diuretics (see PRECAUTIONS [Drug Interactions]).

In heart failure, where blood pressure was either normal or low, transient decreases in mean blood pressure  $>20\%$  were recorded in about half of the patients. This transient hypotension may occur after any of the first several doses and is usually well tolerated, although rarely it has been associated with arrhythmia or conduction defects. A starting dose of 6.25 or 12.5 mg tid may minimize the hypotensive effect. Patients should be followed closely for the first 2 weeks of treatment and whenever the dose of captopril and/or diuretic is increased.

**BECAUSE OF THE POTENTIAL FALL IN BLOOD PRESSURE IN THESE PATIENTS, THERAPY SHOULD BE STARTED UNDER VERY CLOSE MEDICAL SUPERVISION.**

**PRECAUTIONS: General: Impaired Renal Function.** Hypertension—Some hypertensive patients with renal disease, particularly those with severe renal artery stenosis, have developed increases in BUN and serum creatinine. It may be necessary to reduce captopril dosage and/or discontinue diuretic. For some of these patients, normalization of blood pressure and maintenance of adequate renal perfusion may not be possible. **Heart Failure**—About 20% of patients develop stable elevations of BUN and serum creatinine  $>20\%$  above normal or baseline upon long-term treatment. Less than 5% of patients, generally with severe preexisting renal disease, required discontinuation due to progressively increasing creatinine. See DOSAGE AND ADMINISTRATION, ADVERSE REACTIONS [Altered Laboratory Findings]. **Valvular Stenosis**—A theoretical concern, for risk of decreased coronary perfusion, has been noted regarding vasodilator treatment in patients with aortic stenosis due to decreased afterload reduction.

**Surgery/Anesthesia**—If hypotension occurs during major surgery or anesthesia, and is considered due to the effects of captopril, it is correctable by volume expansion.

**Drug Interactions: Hypotension: Patients on Diuretic Therapy**—Precipitous reduction of blood pressure may occasionally occur within the 1st hour after administration of the initial captopril dose in patients on diuretics, especially those recently placed on diuretics, and those on severe dietary salt restriction or dialysis. This possibility can be minimized by either discontinuing the diuretic or increasing the salt intake about 1 week prior to initiation of captopril therapy or by initiating therapy with small doses (6.25 or 12.5 mg). Alternatively, provide medical supervision for at least 1 hour after the initial dose.

**Agents Having Vasodilator Activity**—In heart failure patients, vasodilators should be administered with caution.

**Agents Causing Renin Release**—Captopril's effect will be augmented by antihypertensive agents that cause renin release.

**Agents Affecting Sympathetic Activity**—The sympathetic nervous system may be especially important in supporting blood pressure in patients receiving captopril alone or with diuretics. Beta-adrenergic blocking drugs add some further antihypertensive effect to captopril, but the overall response is less than additive. Therefore, use agents affecting sympathetic activity (e.g., ganglionic blocking agents or adrenergic neuron blocking agents) with caution.

**Agents Increasing Serum Potassium**—Give potassium-sparing diuretics or potassium supplements only for documented hypokalemia, and then with caution, since they may lead to a significant increase of serum potassium. Use potassium-containing salt substitutes with caution.

**Inhibitors of Endogenous Prostaglandin Synthesis**—Indomethacin and other nonsteroidal anti-inflammatory agents may reduce the antihypertensive effect of captopril, especially in low renin hypertension.

**Drug/Laboratory Test Interaction:** Captopril may cause a false-positive urine test for acetone.

**Carcinogenesis, Mutagenesis and Impairment of Fertility:** Two-year studies with doses of 50 to 1350 mg/kg/day in mice and rats failed to show any evidence of carcinogenic potential. Studies in rats have revealed no impairment of fertility.

**Pregnancy: Category C**—There are no adequate and well-controlled studies in pregnant women. Embryocidal effects were observed in rabbits. Therefore, captopril should be used during pregnancy only if the potential benefit outweighs the potential risk to the fetus. Captopril crosses the human placenta.

**Nursing Mothers:** Captopril is secreted in human milk. Exercise caution when administering captopril to a nursing woman, and, in general, nursing should be interrupted.

**Pediatric Use:** Safety and effectiveness in children have not been established although there is limited experience with use of captopril in children from 2 months to 15 years of age. Dosage, on a weight basis, was comparable to that used in adults. Captopril should be used in children only if other measures for controlling blood pressure have not been effective.

**ADVERSE REACTIONS:** Reported incidences are based on clinical trials involving approximately 7000 patients.

**Renal**—About 1 of 100 patients developed proteinuria (see WARNINGS). Renal insufficiency, renal failure, polyuria, oliguria, and urinary frequency in 1 to 2 of 1000 patients.

**Hematologic**—Neutropenia/agranulocytosis have occurred (see WARNINGS). Anemia, thrombocytopenia, and pancytopenia have been reported.

**Dermatologic**—Rash (usually maculopapular, rarely urticarial), often with pruritus and sometimes with fever and eosinophilia, in about 4 to 7 of 100 patients (depending on renal status and dose), usually during the 1st 4 weeks of therapy. Pruritus, without rash, in about 2 of 100 patients. A reversible associated pemphigoid-like lesion, and photosensitivity have also been reported. Angioedema of the face, mucous membranes of the mouth, or of the extremities in about 1 of 1000 patients—reversible on discontinuance of captopril therapy. One case of laryngeal edema reported. Flushing or pallor in 2 to 5 of 1000 patients.

**Cardiovascular**—Hypotension may occur, see WARNINGS and PRECAUTIONS (Drug Interactions) for discussion of hypotension on initiation of captopril therapy. Tachycardia, chest pain, and palpitations each in about 1 of 100 patients. Angina pectoris, myocardial infarction, Raynaud's syndrome, and congestive heart failure each in 2 to 3 of 1000 patients.

**Dysgeusia**—About 2 to 4 (depending on renal status and dose) of 100 patients developed a diminution or loss of taste perception; taste impairment is reversible and usually self-limited even with continued drug use (2 to 3 months). Gastric irritation, abdominal pain, nausea, vomiting, diarrhea, anorexia, constipation, aphthous ulcers, peptic ulcer, dizziness, headache, malaise, fatigue, insomnia, dry mouth, dyspnea, cough, alopecia, and paresthesias reported in about 0.5 to 2% of patients but did not appear at increased frequency compared to placebo or other treatments used in controlled trials.

**Altered Laboratory Findings:** Elevations of liver enzymes in a few patients although no causal relationship has been established. Rarely cholestatic jaundice and hepatocellular injury with or without secondary cholestasis, have been reported. A transient elevation of BUN and serum creatinine may occur, especially in volume-depleted or renovascular hypertensive patients. In instances of rapid reduction of longstanding or severely elevated blood pressure, the glomerular filtration rate may decrease transiently, also resulting in transient rises in serum creatinine and BUN. Small increases in serum potassium concentration frequently occur, especially in patients with renal impairment (see PRECAUTIONS).

**OVERDOSAGE:** Primary concern is correction of hypotension. Volume expansion with an I.V. infusion of normal saline is the treatment of choice for restoration of blood pressure. Captopril may be removed from the general circulation by hemodialysis.

**DOSAGE AND ADMINISTRATION:** CAPOTEN (captopril) should be taken one hour before meals. In hypertension, CAPOTEN may be dosed bid or tid. Dosage must be individualized; see DOSAGE AND ADMINISTRATION section of package insert for detailed information regarding dosage in hypertension and in heart failure. Because CAPOTEN (captopril) is excreted primarily by the kidneys, dosage adjustments are recommended for patients with impaired renal function.

**Consult package insert before prescribing CAPOTEN (captopril).**

**HOW SUPPLIED:** Available in tablets of 12.5, 25, 50, and 100 mg in bottles of 100 (25 mg also available in bottles of 1000), and in UNIMATIC® single dose packs of 100 tablets. (J3-658C)



INNOVATORS IN CARDIOVASCULAR MEDICINE



In Concert at CMA's

# *Command Performance*

February 28 - March 5, 1986  
Westin Bonaventure Hotel, Los Angeles

*Annual Scientific Assembly* offers 50 programs covering clinical, socioeconomic and legislative topics of critical interest to all physicians.

*Scientific and Technical Exhibits* feature outstanding performers offering state of the art medical equipment and health care information — certain to draw rave reviews.

*Hospital Medical Staff Section* spotlights timely issues of concern to hospital medical staffs. Current legislation, DRGs, joint venturing, medical staff bylaws and credentialing will be a few of the highlights of this educational and policymaking forum.

*House of Delegates* convenes to debate pressing issues affecting California physicians. Each member of the Association can take up the baton by testifying at reference committee hearings.

For more information about CMA's 115th Annual Session, contact Barbara Smart at the CMA, 44 Gough Street, San Francisco, CA 94103-1233, (415) 863-5522, ext. 404.

# BALANCED CALCIUM CHANNEL BLOCKER



**CARDIZEM**  
(diltiazem HCl)

balances  
potent  
coronary  
vasodilation  
with a low  
incidence of  
side effects

## Low incidence of side effects

CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

\*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

### References:

1. Starzess WE, McIntyre KM, Parial AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of chronic stable angina pectoris. Report of a cooperative clinical trial. *Am J Cardiol* 49:660-666, 1982.
2. Pool PE, Saegren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. *Chest* 78 (July suppl):234-238, 1980.

## Reduces angina attack frequency\*

42% to 46% decrease reported in multicenter study.<sup>1</sup>

## Increases exercise tolerance\*

In Bruce exercise test,<sup>2</sup> control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ( $P<.005$ ).

**CARDIZEM**<sup>®</sup>  
(diltiazem HCl)

**THE BALANCED  
CALCIUM CHANNEL BLOCKER**

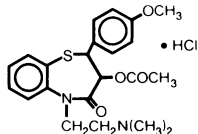


## PROFESSIONAL USE INFORMATION



### DESCRIPTION

**CARDIZEM®** (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)-one, 3-(acetoxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride, (+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

### CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

**Mechanisms of Action.** Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. **Angina Due to Coronary Artery Spasm:** CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. **Exertional Angina:** CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

**Hemodynamic and Electrophysiologic Effects.** Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 953 chronically treated patients.

**Pharmacokinetics and Metabolism.** Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

### INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM

is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).

2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

### CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

### WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Conductive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

### PRECAUTIONS

**General.** CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

**Drug Interaction.** Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

**Carcinogenesis, Mutagenesis, Impairment of Fertility.** A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in *in vitro* bacterial tests. No intrinsic effect on fertility was observed in rats.

**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers.** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

**Pediatric Use.** Safety and effectiveness in children have not been established.

### ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%),

headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

### OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD<sub>50</sub> in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD<sub>50</sub> in these species were 60 and 38 mg/kg, respectively. The oral LD<sub>50</sub> in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

### DOSAGE AND ADMINISTRATION

**Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm.** Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

**Concomitant Use With Other Antianginal Agents:**

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

### HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

Another patient benefit product from



---

# Professional liability protection?



**There's more  
to consider  
than cost.**

# The Mutual Protection Trust offers:

- ✓ **Experience.** CAP/MPT is the oldest California trust providing professional liability protection.
- ✓ **Quality.** A stringent screening process — each member has a voice in the selection of new members.
- ✓ **Loss Prevention Programs.** Education reduces malpractice risk.
- ✓ **Reinsurance.** Limits assessment exposure.
- ✓ **Retroactive Coverage.** For qualified members.
- ✓ **Savings.** Compare our cost with other **experienced** providers of malpractice protection:

Specialty	1986 CAP/MPT Estimated Cost*
Allergy	\$ 2,012
Cardiology with invasive vascular procedures	9,153
Dermatology — no radiation or hair transplants	4,393
Family Practice — no surgery	4,393
Family Practice — major surgery	14,991
Internal Medicine with invasive vascular procedures	9,153
Neurology	2,012
Orthopedics with spinal surgery	18,449
Otolaryngology— doing plastic surgery, board certified	14,991
Pediatrics — General, with invasive vascular procedures	9,153
Psychiatry — no electro-convulsive therapy	2,012
Radiology — including coronary angiography	9,153

\*These rates include dues and assessments for a CAP/MPT member with 50 or more months of membership or retroactive coverage (matured rate). CAP/MPT offers coverage limits of \$1 million per occurrence with an aggregate of \$3 million per year.

In addition to dues and assessments, CAP/MPT members pay a one-time initial trust contribution based on risk classification. This can be paid in installments and is refundable under the terms of the MPT Agreement.



**MUTUAL PROTECTION TRUST**

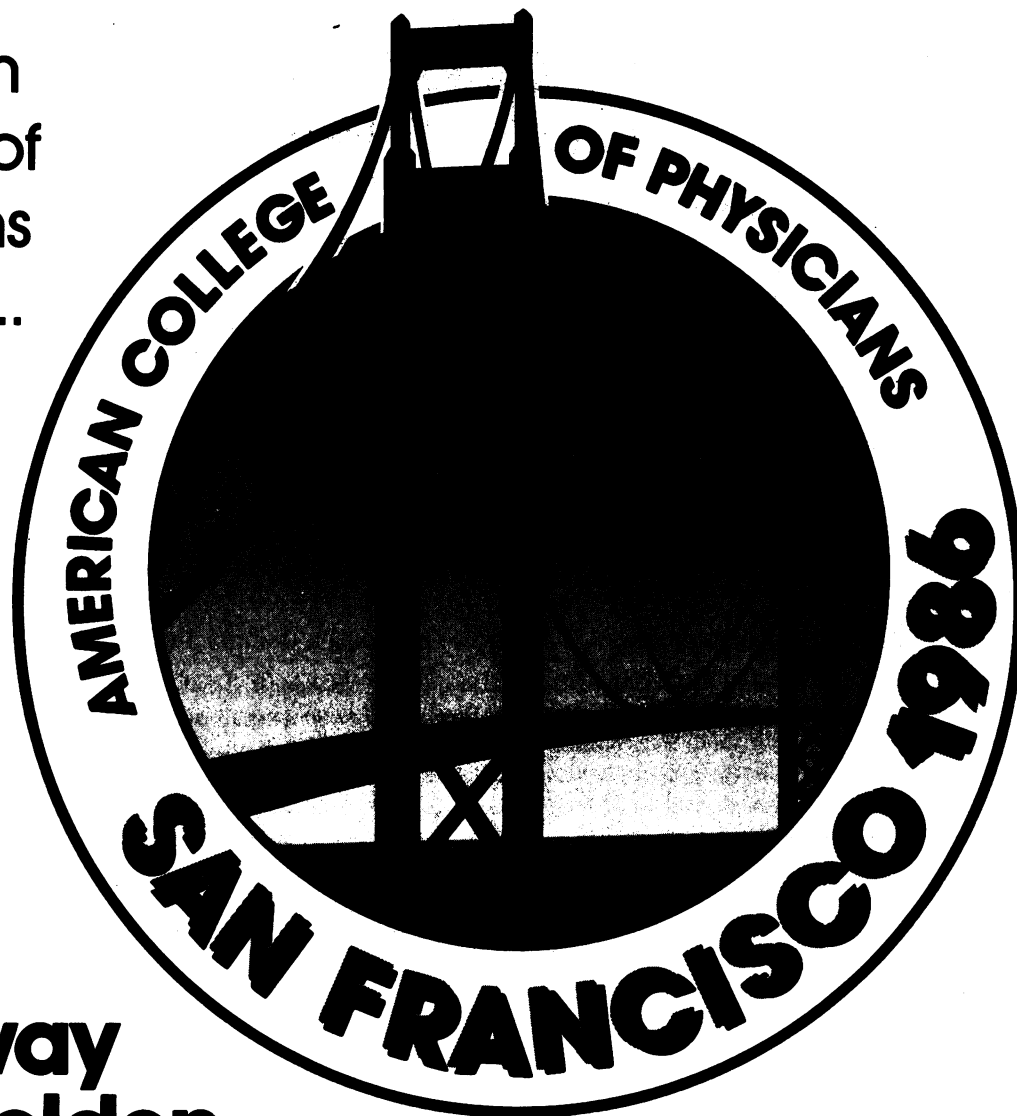
**Cooperative of American Physicians, Inc.**

P.O. Box 4230  
Los Angeles, CA 90078

**Call to find out what your cost would be with CAP/MPT.**

**(800) 252-7706**

American  
College of  
Physicians  
presents...



# Gateway to a Golden Medical Opportunity

67th ANNUAL SESSION  
APRIL 10-13, 1986  
MOSCONE CENTER

**Join us in San Francisco for Internal Medicine's Premier Meeting!**

- Plan your own CME curriculum from over 300 scientific presentations . . . covering 14 major internal medicine subspecialties
- Discuss your problem cases with medicine's leading teachers and clinicians
- Find out how the new science of Medical Informatics can help you now and in the future
- Learn how discoveries in the "New Genetics" are affecting clinical medicine
- Choose from either of two pre-meeting courses on Critical Care or Management of Acute Myocardial Infarction
- Bring your spouse and family to enjoy a full schedule of special activities

**Send for your 1986  
Annual Session Scientific Program Guide**

**YES, please mail me the '86  
Program Guide**

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Telephone toll free:  
**(800) 523-1546**

(In Pennsylvania:  
**(215) 243-1200**)

☐ ACP member ☐ non-member

American College of Physicians  
4200 Pine Street, Philadelphia, PA 19104



## 11:00 p.m.

Time. It seems as though we never have enough. Just when you thought you'd caught up with paperwork, it's one more late night.

You'd always figured on early mornings and caring for patients. You knew people would need you in the middle of the night. That's medicine. But you had not figured on late nights taking care of your practice.

If you spend too much time on business—maybe more than on medicine—we can help. We're here to ease some of your office's administrative burden. We're Professional Office Business Systems from Blue Cross of California.

We have a physician-designed practice management system to handle virtually all of your office paperwork. The system automates insurance filings, and it will eliminate paper by permitting electronic submission of Blue Cross and Medicare claims.

The practice management system handles a large and expanding list of office functions: accounts receivable management, patient and insurance billing, customized statistical reporting, accounts payable, patient scheduling, general ledger and word processing.

Automation can eliminate many of the tedious and redundant tasks that take up much of your valuable staff time.

If time is a problem and taking away from your medicine, call us. We can help.

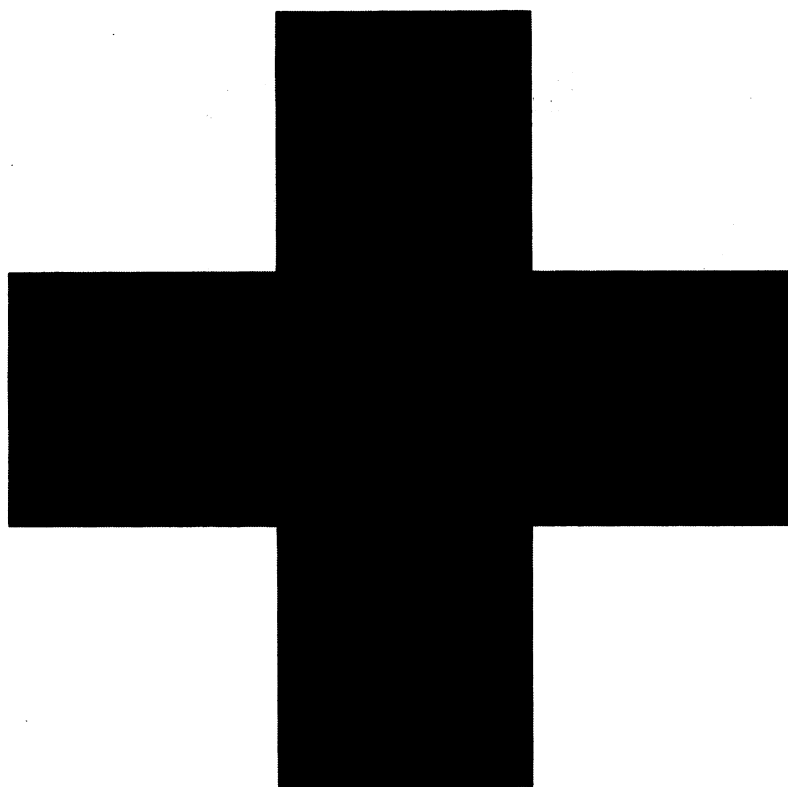
## Professional Office Business Systems

a Blue Cross of California Company

**(415) 645-3100**

For Northern California  
Doctors Only





# **THE ONLY SENIOR CITIZEN NOT ELIGIBLE FOR SOCIAL SECURITY.**

The American Red Cross is one of our nation's oldest, most venerated public service organizations. And since we receive no Federal appropriations for general operations, we must rely on you for donations. Which simply means, without your time and money, there will be no Red Cross. Please don't let an old friend down.



**American Red Cross**



A Public Service of The Publication



The stairs seem steeper today



That's the unpredictability of MIXED ANGINA—vasoconstriction coexisting with fixed coronary lesion—to produce a critical reduction of myocardial blood flow.

MIXED ANGINA

#### Brief Summary

#### PROCARDIA® (nifedipine) Capsules

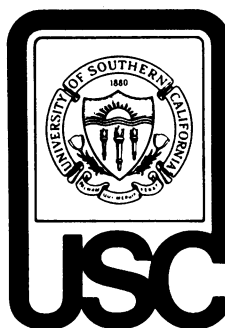
For Oral Use

**INDICATIONS AND USAGE:** I. **Vasospastic Angina:** PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers. II. **Chronic Stable Angina (Classical Effort-Associated Angina):** PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete. Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta-blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See **WARNINGS**.) **CONTRAINDICATIONS:** Known hypersensitivity reaction to PROCARDIA. **WARNINGS:** **Excessive Hypotension:** Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers. Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery. **Increased Angina:** Occasional patients have developed well-documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone. **Beta Blocker Withdrawal:** Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA. **Congestive Heart Failure:** Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event. **PRECAUTIONS:** **General:** **Hypotension:** Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See **WARNINGS**.) **Peripheral edema:** Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction. **Laboratory tests:** Rare, usually transient, but occasionally significant elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT and SGPT have been noted. The relationship to PROCARDIA therapy is uncertain in most cases, but probable in some. These laboratory abnormalities have rarely been associated with clinical symptoms, however, cholestasis with or without jaundice has been reported. Rare instances of allergic hepatitis have been reported. Limited clinical studies have demonstrated a moderate but statistically significant decrease in platelet aggregation and increase in bleeding time in some PROCARDIA patients. No clinical significance for these findings has been demonstrated. Although PROCARDIA has been used safely in patients with renal dysfunction and has been reported to exert a beneficial effect in certain cases, rare, reversible elevations in BUN and serum creatinine have been reported in patients with pre-existing chronic renal insufficiency. The relationship to PROCARDIA therapy is uncertain in most cases but probable in some. **Drug Interactions:** Beta-adrenergic blocking agents: (See **Indications and Warnings**.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina. Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination. Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization. Coumarin anticoagulants: There have been rare reports of increased prothrombin time in patients taking coumarin anticoagulants to whom PROCARDIA was administered. Cimetidine: A study in six healthy volunteers has shown a significant increase in peak nifedipine plasma levels (80%) and area-under-the-curve (74%) after a one week course of cimetidine at 1000 mg per day and nifedipine at 40 mg per day. Ranitidine produced smaller, non-significant increases. If nifedipine therapy is initiated in a patient currently receiving cimetidine, cautious titration is advised. **Carcinogenesis, mutagenesis, impairment of fertility:** Nifedipine was administered orally to rats for two years and was not shown to be carcinogenic. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose. *In vivo* mutagenicity studies were negative. **Pregnancy:** Pregnancy Category C. Nifedipine has been shown to be teratogenic in rats and embryotoxic in rats, mice and rabbits. There are no adequate and well controlled studies in pregnant women. PROCARDIA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **ADVERSE REACTIONS:** The most common adverse events include dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, shortness of breath, diarrhea, constipation, gastrointestinal cramps, flatulence, inflammation, joint stiffness, shakiness, jitteriness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, sexual difficulties, thrombocytopenia, anemia, leukopenia, purpura, allergic hepatitis, gingival hyperplasia, and erythromelalgia. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension. In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients. **HOW SUPPLIED:** Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

Revised April 1985  
© 1982, Pfizer Inc.

**Pfizer** LABORATORIES DIVISION  
PFIZER INC.



University of  
Southern California  
School of Medicine  
and Childrens Hospital  
of Los Angeles

## THE SIXTEENTH ANNUAL REVIEW OF PEDIATRICS

May 12-16, 1986.

**TUITION:** Physicians \$395,  
Residents \$250

**CREDIT:** 25 hours of Category I AMA/CMA credit.

#### For further information contact:

Associate Dean, USC School of Medicine  
Postgraduate Division  
2025 Zonal Avenue, KAM 307, Los Angeles, CA 90033  
(800) 421-6729 outside California  
(800) 321-1929 inside California

## INTERNISTS FAMILY PRACTITIONERS

FHP, a rapidly expanding multi-specialty group practice, has full time opportunities for residency trained, Board certified (or eligible) Internists and Family Practitioners. These Southern California positions offer a full range of in-hospital and outpatient responsibilities in a comprehensive care environment. Administrative opportunities are also available.

For more information, please write or call William Trainor, Manager of Professional Staffing, toll-free at 1-800-446-2255 (in California, call 1-800-336-2255).

# FHP

Professional Staffing  
9900 Talbert Avenue • P.O. Box 8000  
Fountain Valley, California 92708-8000



# Put **ZORprin** (ASPIRIN) Zero-Order Release in your circle of arthritic therapy



**ZORprin® provides  
800 mg of aspirin in a unique,  
patented zero-order release  
delivery system.**

**Convenient two-tablet, b.i.d. dosage**

- Easy-to-remember regimen improves compliance
- 24-hour pain relief

**Efficacy comparable to NSAIs**

- Helps reduce morning stiffness and nighttime pain

**Side effect profile superior to plain aspirin...  
comparable to NSAIs**

- ZORprin® is economical arthritic therapy
- Prescription only

The ideal method to maintain therapeutic control



Pioneers in medicine for the family



**Boots Pharmaceuticals, Inc.**  
6540 LINE AVENUE, P.O. BOX 6750  
SHREVEPORT, LOUISIANA 71106-9989

*See brief summary of prescribing  
information on next page.*

Before prescribing, see complete prescribing information in SK&F CO. literature or PDR. The following is a brief summary.

★

#### WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

**Contraindications:** Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

**Warnings:** Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum  $K^+$  levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict  $K^+$  intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

**Precautions:** The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

**Supplied:** 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ-139

a product of

**SK&F CO.**

Carolina, P.R. 00630

©SK&F Co., 1985

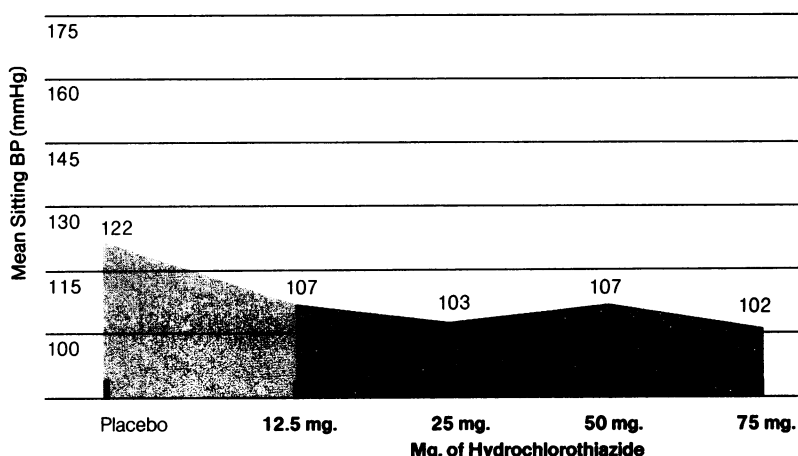
The unique  
red and white  
Dyazide® capsule:  
Your assurance of  
SK&F quality.

# The Benefits of Less

Low doses of hydrochlorothiazide can provide most of the antihypertensive effect of larger doses.<sup>1</sup>

Increasing dosage above 25 mg. daily or improving bioavailability will not lead to increased antihypertensive efficacy in the majority of patients, but can result in a higher incidence of hypokalemia, hyperuricemia and hyperglycemia.<sup>2</sup>

HYDROCHLOROTHIAZIDE: FLAT DOSE-RESPONSE CURVE<sup>3</sup>



For the benefits of low dose diuretic therapy\*  
with the added benefit of  
potassium-sparing triamterene

P R E S C R I B E  
**DYAZIDE®**  
25 mg Hydrochlorothiazide/50 mg Triamterene/SKF

\*Not for initial therapy. See boxed warning.

1. Kaplan, N.: Systemic Hypertension: Therapy, in Braunwald, E. (ed.), Heart Disease. A Textbook of Cardiovascular Medicine, Philadelphia, W.B. Saunders Co., vol. 1, pp. 922-951.
2. Dialogues in Hypertension, Hypertension Update II: New Developments in Antihypertensive Therapy, Jan. 1985, Health Learning Systems Inc.

3. Adapted from Beerman, B., and Groschinsky-Grind, M.: Antihypertensive Effect of Various Doses of Hydrochlorothiazide and Its Relation to the Plasma Level of the Drug, Eur. J. Clin. Pharmacol. 13: 195-201, 1978.

# Playing more of your favorite tape requests.

## ***The SCPIE-on-Call Loss Prevention Program***

Our top-rated "Call In Program" has been expanded for the listening audience with new tapes on new subjects.

SCPIE-on-Call, a free service of Southern California Physicians Insurance Exchange, is a series of tape-recorded Loss Prevention reports for physicians and office staff. Most malpractice claims can be avoided. These reports give examples of actual losses, and describe how to avoid them.

The expanded series now includes reports on specialty practice and on frequently asked questions about insurance.

The SCPIE-on-Call operator is ready to take your requests

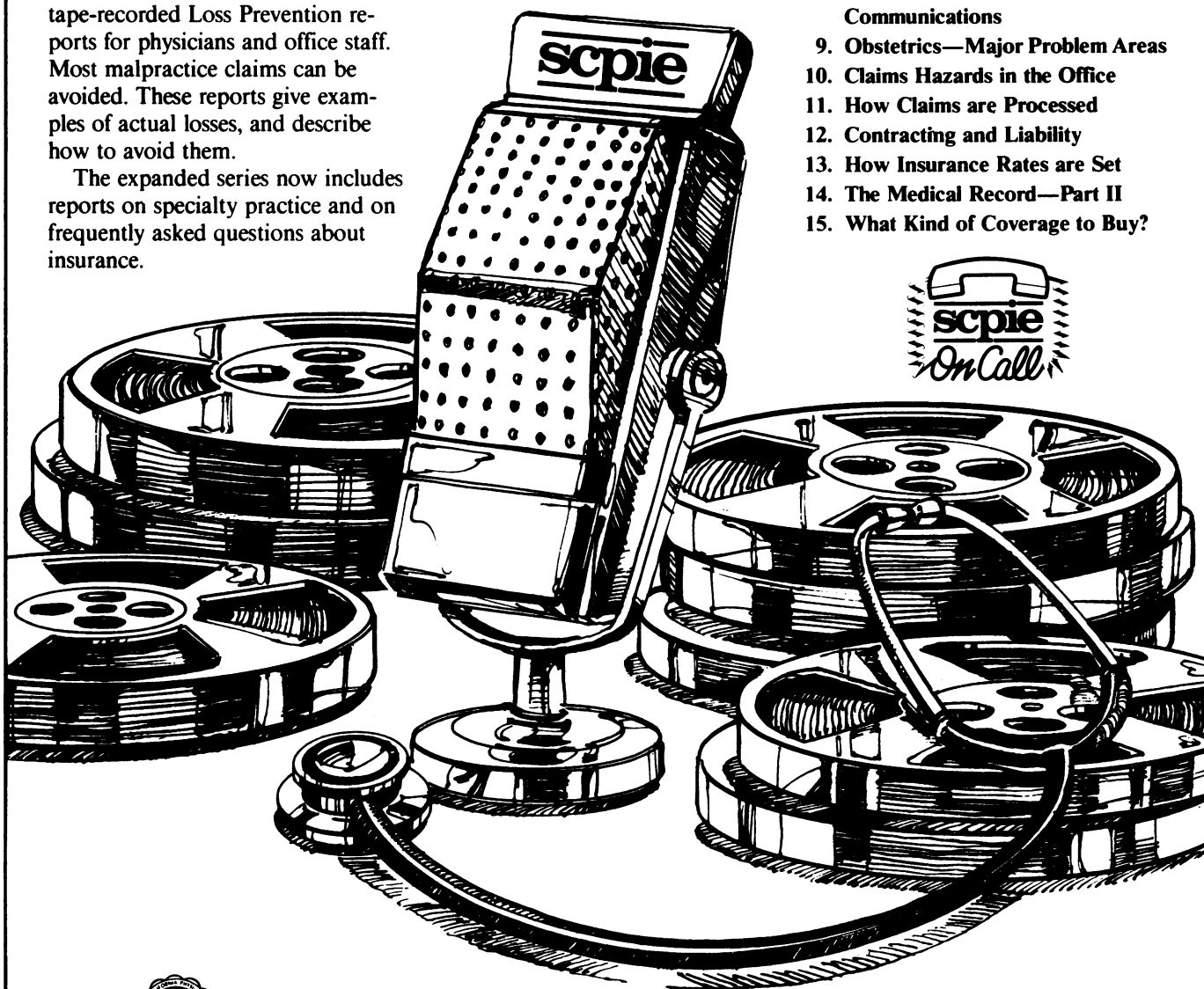
*9 a.m. to 8 p.m. Monday-Friday  
10 a.m. to 6 p.m. Saturday*

Call the toll-free number

**1-800-821-3887**  
(In Southern California)

Ask for tapes by number:

1. The Medical Record
2. Informed Consent
3. Doctor-Patient Rapport
4. Early Warnings of Claims
5. Laboratory Report Follow-Up
6. Requests for Copies of Records
7. Pediatric Claims
8. Obstetric Claims—Communications
9. Obstetrics—Major Problem Areas
10. Claims Hazards in the Office
11. How Claims are Processed
12. Contracting and Liability
13. How Insurance Rates are Set
14. The Medical Record—Part II
15. What Kind of Coverage to Buy?



Sponsored by SOCAP: The medical associations and societies of Kern County, Los Angeles County, Orange County, San Bernardino County, San Luis Obispo County, Santa Barbara County and Ventura County.

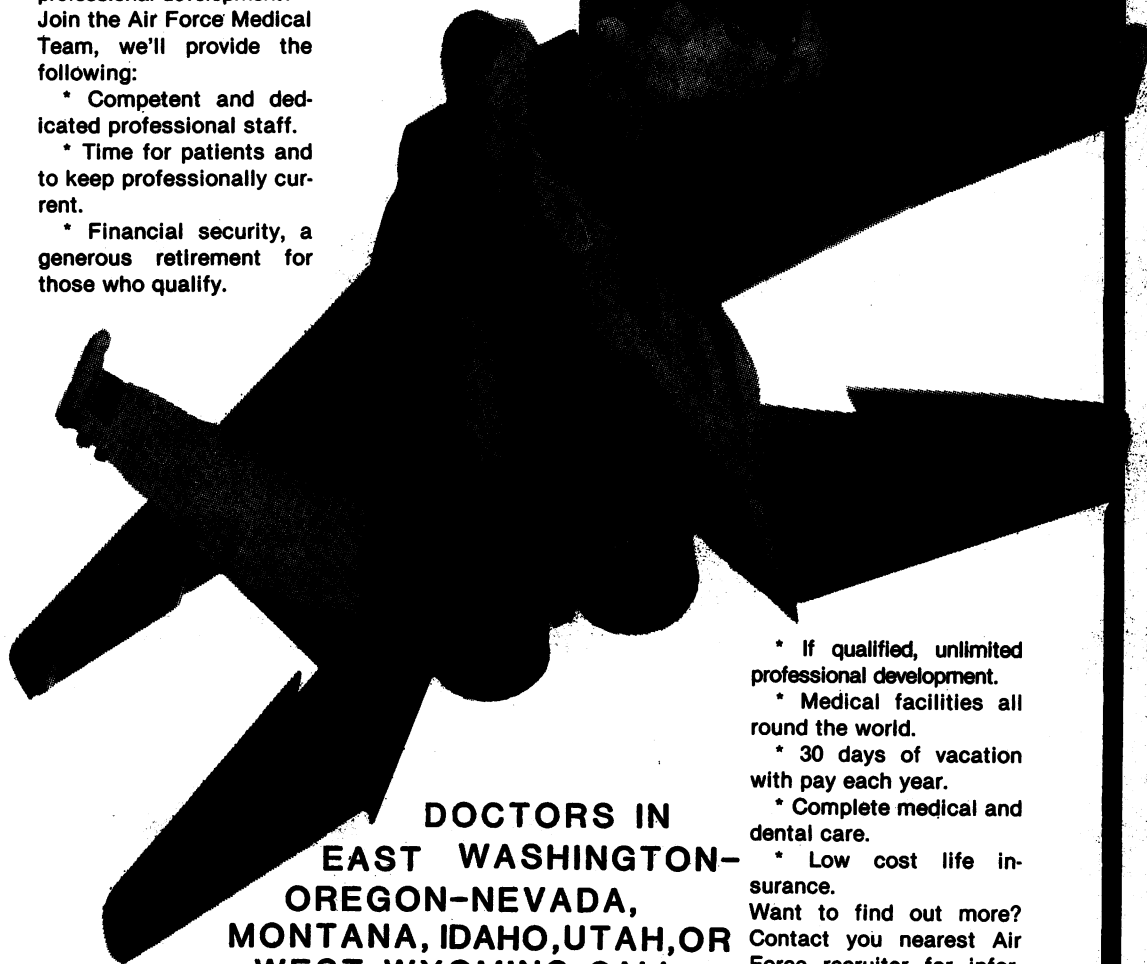
**A PRESCRIPTION FOR  
PHYSICIANS**

Bothered by:

- \* Too much paperwork?
- \* The huge burden of office overhead?
- \* Malpractice insurance costs?
- \* Not enough time for the family?
- \* No time to keep current with technology and new methods?
- \* No time or money for professional development?

Join the Air Force Medical Team, we'll provide the following:

- \* Competent and dedicated professional staff.
- \* Time for patients and to keep professionally current.
- \* Financial security, a generous retirement for those who qualify.



**DOCTORS IN  
EAST WASHINGTON-  
OREGON-NEVADA,  
MONTANA, IDAHO, UTAH, OR  
WEST WYOMING CALL**

- \* If qualified, unlimited professional development.
  - \* Medical facilities all round the world.
  - \* 30 days of vacation with pay each year.
  - \* Complete medical and dental care.
  - \* Low cost life insurance.
- Want to find out more?  
Contact you nearest Air Force recruiter for information at no obligation.

**CAPTAIN STEVE BENTLEY (801) 524-4008 COLLECT**

**AIR  
FORCE**

**A great way of life.**

# ALWAYS ON CALL:

## AT&T'S NEW DOCTOR'S SOLUTION ASSISTS YOU ROUND-THE-CLOCK WITH EVERYTHING FROM ACCOUNTS RECEIVABLE TO SCHEDULING.

Few doctors like to think of their practice as a business, but of course it is.

So the less you have to think about business, the more you can concentrate on medicine.

That's why AT&T tailored a complete hardware and software package specifically for the medical profession. The Doctor's Solution.

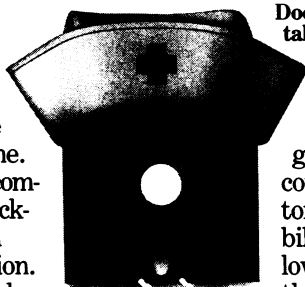
It's just one member of a whole family of Health Care Information Systems. AT&T Doctor's Solution provides total office management for single and multi-doctor practices.

Far from forcing you to change the way you run your practice, Doctor's Solution simply allows you to run it more efficiently with help like this:

**Automated billing** gathers all charges to each patient—including exams, tests and prescriptions—and automatically calculates a single, comprehensive bill.

**Accounts receivable** tracks all receivables, selects balance-forward or open-item statements, sets aging intervals, and spots delinquent accounts. All of which improve your collection rates.

**Practice management** improves the flow of your



Doctor's Solution software takes care of your paper work so you can take care of your patients.

practice with the ongoing maintenance of complete patient histories. Both clinical and billing information follow every patient through your office.

**Patient scheduling** by practice, doctor, week or month—including rounds and vacations—helps you get the most out of your time so you can give the most to your patients.

**Third-party billing** increases your cash flow by accommodating unlimited fee schedules and generating a variety of forms and invoices.

**Remote access** to your office system. Now you can get complete clinical and business information at the hospital, at home—anywhere there's a phone, a terminal or PC, and a modem.

But one of the nicest features about Doctor's Solution is that it's backed by AT&T's Small Business Connection. Which means our specialists in the medical field will make sure you get the right hardware, the right software and the right training.

Now you can tie your hospital to your office with just a phone, a modem and a terminal or PC.

As your practice grows, these specialists will help you keep your system right in step—accepting new doctors, new procedures and new diagnostics.

What's more, Doctor's Solution will work with every UNIX™ System-based computer AT&T makes. Just one more example of "The Computers With The Future Built In."

And if you have a problem? We not only have a Service Hotline; we even do over-the-phone software diagnostics.

It's all part of AT&T's unique approach to small business. You don't just buy a system.

You buy AT&T's end-to-end responsibility for that system.

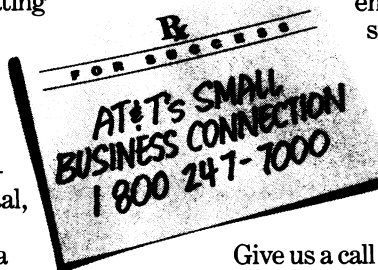
And you buy it from a single source with a proven past.

And a very healthy future.

Give us a call at 1 800 247-7000.

We'll show you how to get your practice a lot closer to perfect.

© 1985 AT&T Information Systems



**AT&T**

The right choice.

# Classified Advertisements

The rate for each insertion is \$5 per line (average six words per line) with five line (\$25) minimum. Box number charge: \$5 each month.

**Classified display rates \$50 per inch.**

Copy for classified advertisements should be received not later than the first of the month preceding issue. All copy must be typed or printed. • Classified advertisers using Box Numbers forbid the disclosure of their identity. Your inquiries in writing will be forwarded to Box Number advertisers. The right is reserved to reject or modify all classified advertising copy in conformity with the decisions of the Advertising Committee.

**Please Type or Print Advertising Copy**

## Classified Advertisements Are Payable in Advance

THE WESTERN JOURNAL OF MEDICINE  
P.O. BOX 7602, SAN FRANCISCO, CA 94120-7602

### PHYSICIANS WANTED

**CALIFORNIA**—Board Certified/eligible or residency trained emergency physician wanted to join 320 physician multispecialty group. Competitive salary and excellent fringe benefits. Ninety miles from Sierra skiing and San Francisco. California license required. Send curriculum vitae to Mrs. Carolyn Whelan, The Permanente Medical Group, Inc., PO Box 254999, Sacramento, CA 95825. An equal opportunity employer.

**CALIFORNIA, RURAL AMERICAN AND OVERSEAS:** Primary care physicians and OB/GYN needed for locum and permanent placements in CA, Saudi Arabia and, southwestern US. Excellent financial package, practice management and affiliation with a dynamic healthcare company. CV to: Beverly Froy, Westworld Healthcare Resources, 23832 Rockfield Rd., Lake Forest, CA 92630; (800) 847-1596.

**FAMILY PRACTICE-INTERNAL MEDICINE-SURGEON.** Multispecialty clinic in Northern Idaho Panhandle. Nominal lease includes fully-equipped office and treatment suites with receptionist and janitorial services provided. Clinic includes x-ray, lab and pharmacy. Billing services available. Located in a four-season playground rich with recreational opportunities. Just 20 minutes from a 14-run ski resort. For information: (208) 784-1221, X304. Mail résumés to: Shoshone Medical Center, Jacobs Gulch, Kellogg, ID 83837.

**INTERNIST** with sub-specialty to join six established in Mountain View, California. Near 450 bed, well equipped hospital and Stanford University. Send CV to El Camino Internal Medical Group, Inc., 125 South Dr., Mountain View, CA 94040.

**THORACIC VASCULAR GENERAL SURGEON**—To associate with senior Surgeon. Well established referral practice. Salary plus percentage. Central California. Send curriculum vitae to Box 7001, Western Journal of Medicine, 44 Gough St., San Francisco, CA 94103.

**THE UNIVERSITY OF UTAH,** Department of Family and Community Medicine, is seeking two BC/BE Family Physicians for clinical positions in university-run community health centers. The population served is a challenging, multi-ethnic one. Full range of family practice including obstetrics, is required. Flexibility exists for resident teaching, research, and post-graduate work towards MSPH. Attractive base salary, benefits, practice incentive, and vacation time. If interested call or write Dr Stephen Ratcliffe, University of Utah, DFCM, 50 North Medical Dr., Salt Lake City, UT 84132; (801) 581-5529.

### PHYSICIANS WANTED

**OBSTETRICIAN-GYNECOLOGIST**—Personable and industrious female Obstetrician-Gynecologist desired to join 3-physician department in 28-physician multispecialty group. Immediate practice opportunity. Drawing area 185,000. Western slope of the Rockies. Excellent hospital facilities. Superb living conditions. Unexcelled skiing and outdoor recreation. Primary fee-for-service. HMO option. Please send curriculum vitae and references to Mary Beard, MD, Ogden Clinic, 4650 Harrison, Ogden, UT 84403.

**FAMILY PRACTITIONER**—Tulare County, California. Board certified/eligible Family Practitioner to practice in an outpatient clinic, which includes inpatient duties, with 13 physicians. Consider a semi-rural lifestyle with cultural amenities, the Coast and the Sierra Nevada Mountains easily accessed. Salary: \$81,236 to \$85,376 annually. The County provides a benefit package which includes malpractice insurance coverage. Send CV to Tulare County Personnel, Courthouse, Room 106, Visalia, CA 93291; (209) 733-6266. An Affirmative Action Employer.

**OB/GYN**—Tulare County, California. Board certified/eligible OB/GYN to practice in an outpatient clinic, which includes inpatient duties, with 13 physicians. Consider a semi-rural lifestyle with cultural amenities of metropolitan areas easily accessed and the Sierra Nevada Mountains nearby. Salary: \$88,837 to \$93,365 annually. The County provides a benefit package which includes malpractice insurance coverage. Send CV to: Tulare County Personnel, Courthouse, Room 106, Visalia, CA 93291; (209) 733-6266. An Affirmative Action Employer.

**OPPORTUNITY AVAILABLE** for Family Practice physician interested in surgery and OB in group practice in desirable rural area. Clinic and hospital well-equipped. Call/write F. L. Nutter, Administrator, 1101 Texas, Deer Lodge, MT 59722; 1 (406) 846-2212.

**INTERNIST** or internal medicine subspecialist to associate with recently established Internist/Rheumatologist in growing Northern California community of 150,000. Incentives offered. Reply with CV to Rex Adams, MD; PO Box 5375, Modesto, CA 95352-5375.

**GENERAL INTERNAL MEDICINE SPECIALIST** position open with 35 member multispecialty group. Excellent practice opportunity; full range of benefits; immediate shareholder status; all practice costs paid. For more information contact: Colin Wells, MD, Recruitment Coordinator, or David Graham, Associate Administrator, San Luis Medical Clinic, Ltd., 1235 Osos St., San Luis Obispo, CA 93401.

### PHYSICIANS WANTED

**FAMILY PRACTICE PHYSICIAN**—Salaried position in rural health care system serving tri-cultural population (Hispanic, Navajo, and Anglo) in Northwest New Mexico; Spanish language very desirable. Salary level negotiable depending on qualifications; liberal fringe benefits package. Contact John Glass, Presbyterian Medical Services, PO Box 2267, Santa Fe, NM 87504; (505) 982-5565.

**ENT:** Third partner for active, established, practice—all aspects of ENT, in San Francisco Bay Area. Salary negotiable. Reply Box 7007, Western Journal of Medicine, 44 Gough St., San Francisco, CA 94103.

**ONCOLOGIST/HEMATOLOGIST** needed to join two other Oncologists/Hematologists in a 32-member multispecialty group located in San Luis Obispo, California. Board certified or eligible. Excellent practice opportunity: benefits and retirement program; all practice costs paid; immediate shareholder status. Send CV to San Luis Medical Clinic, Ltd., Attn: Colin J. Wells, MD, Recruitment Coordinator, 1235 Osos St., San Luis Obispo, CA 93401.

**OTOLARYNGOLOGIST:** BC/BE and also interested in facial plastics to join eighteen physician primary care and multispecialty group practice in beautiful Pacific Northwest setting. Reply to Shane Spray, 1400 East Kincaid, Mount Vernon, WA 98273; (206) 428-2524.

**OCCUPATIONAL MEDICINE—INTERNIST:** Established, dynamic, expanding practice providing wide range of services to business and industry, located in highly desirable residential central Contra Costa County 30 minutes from San Francisco, seeks well trained, hard working clinician with knowledge of Occupational Medicine or willingness to learn, and possessing excellent administrative and business skills. Association now, progressing to equity position. Salary negotiable. Leonard Davis, MD, Ridgecrest Medical Group, 1844 San Miguel Dr., Ste. 107, Walnut Creek, CA 94596; (415) 938-1166.

**BEAUTIFUL CALIFORNIA CENTRAL COAST**—Eight man, multispecialty medical group, seeking a BC/BE Family Practice physician, with broad based practice interests. An expanding population demands that we plan for internal growth. Be prepared to step into an active, ready made practice with group practice conveniences and rewards. Excellent salary/fringe benefits package leading to partnership buy-in opportunities. Address CV and references to: Patrick M. Quigley, Sr., Administrator, Valley Medical Group, 136 North Third St., Lompoc, CA 93436; (805) 736-1253.

**BEAUTIFUL CALIFORNIA CENTRAL COAST**—Eight man, multispecialty medical group, seeking a Physician BC/BE in Internal Medicine, with broad based practice interests. An expanding population demands that we plan for internal growth. Be prepared to step into an active, ready made practice with group practice conveniences and rewards. Excellent salary/fringe benefits package leading to partnership buy-in opportunities. Address CV and references to: Patrick M. Quigley, Sr., Administrator, Valley Medical Group, 136 North Third St., Lompoc, CA 93436; (805) 736-1253.

**PSYCHIATRIST** needed to function as the medical director of a 30 bed child/adolescent psychiatric unit at Utah Valley Regional Medical Center, Provo, Utah. UVRMC is a 389 bed hospital 45 miles south of Salt Lake City. Must have expertise in biological psychiatry as well as psycho-pharmacology. Must be an individual who can work well in a multi-discipline treatment environment. Position is hospital based with a salary of \$100,000. Candidates must be Board eligible. Contact Mrs. Bonham, c/o Job Service, 1895254, 1550 North 200 West, PO Box 1339, Provo, UT, 84603; (801) 373-7500.

**ONCOLOGIST-GASTROENTEROLOGIST**—Excellent opportunity on Northern California coast, to join thriving practice of two general internists. Send CV to Crescent City Internal Medicine, 200 A St., Crescent City, CA 95531; (707) 464-8331.

## PHYSICIAN WANTED

**FAMILY PRACTICE PHYSICIAN BC**—Scenic Northwest. Tacoma-Pierce County Health Department Urban Ambulatory Care System of four clinics. Immediate openings for Family Practice Physician BC. Full-scope Family practice, hospital SIF privileges. New facilities, excellent salary and fringes. Contact: S. W. Zamberlin, Personnel/Employee Relations Manager, Tacoma-Pierce County Health Department, 3629 South D St., Tacoma, WA 98408; (206) 591-6500.

**NORTHERN CALIFORNIA, EMERGENCY MEDICINE**—Full-time positions available in the Emergency Room at The University of California Davis Medical Center. The University serves a large region of Northern California and is a major trauma center. Emergency physicians teach and supervise medical students and housestaff in addition to treating patients, primarily. Opportunities exist for involvement in other School of Medicine teaching activities. Applicants should send Curriculum Vitae to Robert W. Derlet, MD, University of California Davis Medical Center, 2315 Stockton Blvd., Department of Emergency Medicine, Trailer 1219, Sacramento, California 95817.

**SOUTHERN CALIFORNIA**—Orange County Board certified/eligible Family Practitioner needed to join existing group practicing in two separate locations as walk-in extended hour facilities with primary care orientation. Hospital Administrator Private and/or Surgery Assisting optional. Reply with CV to M. Ackerson, 1822½ Newport Blvd., Costa Mesa, CA 92627.

**ENT position open** with 35-member multispecialty group; BC/BE; immediate opening. Excellent practice opportunity; full range of benefits plus immediate Shareholder status; all practice costs paid. Central Coast of California. Submit CV to Colin J. Wells, MD, Recruitment Coordinator, 1235 Osos St., San Luis Obispo, CA 93401.

**NORTHERN CALIFORNIA—PRIMARY CARE:** Small multispecialty group seeks a fourth member Board certified in either Family Practice or Internal Medicine. Arcata is a coastal community in Redwood Country offering a unique combination of rural lifestyle in a university town. Send CV to: Bruce Kessler, MD, Arcata Family Medical Group, 4555 Valley West Blvd., Arcata, CA 95521; (707) 822-4603.

**JOB OPENING**—A rural hospital in Southern Utah is seeking the services of an Internal Medicine Specialist to establish practice in the immediate area. This person would be expected to diagnose and treat disease and injury of human internal organ systems, and examine patients for symptoms of organic or congenital disorders and determine nature and extent of injury or disorder using diagnostic aids. This person would also serve as the Medical Director of the hospital's Intensive Care/Coronary Care Unit. Minimum requirements are a medical degree and completion of an internal medicine residency. Hospital will provide office space at no charge for the period of one year, and will also provide a loan guarantee of up to \$10,000 per month during the first year of practice. The position is open immediately and would normally be 40 hours a week, although some call will be expected, particularly in the Intensive Care Unit, and the physician may be asked to work in hospital's emergency room. For further information please contact Utah Job Service, Cedar City office, 160 E. 200 N., Cedar City, UT; (801) 586-6585. J.O. #0580615

**SPOKANE, WA:** Well established family medicine practice and minor emergency center seeks a full time Board certified Family Physician. Salary and fringe benefits are negotiable with future opportunity to join partnership. Contact Laurel M. Maudlin, Clinic Manager, East 9807 Sprague Ave., Spokane, WA 99206; (509) 924-1120.

**DERMATOLOGIST**—An expanding HMO in San Francisco is seeking a Board certified Dermatologist for a half-time or full-time position. Outpatient and inpatient responsibilities for consultations by referral. Send CV to Robert Mithun, MD, Medical Director, French Hospital Health Plan, 4131 Geary Blvd., San Francisco, CA 94118.

## PHYSICIAN WANTED

**INTERNIST OR SUBSPECIALIST, BC/BE,** needed for staff physician in ambulatory care/admitting at the VA Medical Center, Martinez. The VAMC Martinez is a 402 bed hospital fully affiliated with the University of California Davis Medical School. Martinez is located 35 miles east of San Francisco. The VA offers liberal annual and sick leave benefits. Write Timothy Odell, MD, 150 Muir Road, Martinez, CA 94553; Equal Opportunity Employer.

**PHYSICIAN SHORTAGE**—Family Medicine Physicians needed in Seattle Suburban Community now. In response to community need, a major full-service hospital is encouraging the development of Family Medicine Physician Practices. Commercial financing contacts are being arranged by the hospital. This high-growth, high-employment community has some existing practices available. For more information, please call or write The Friedrich Group, Inc., 9284 Ferncliff N.E., Bainbridge Island, WA 98110; (206) 842-5248 or (206) 329-0417.

**WASHINGTON COASTAL COMMUNITY** serving a population of 65,000 is actively recruiting the following specialists: Orthopedic Surgeon, Urologist, Otolaryngologist. A variety of practice support options are available, i.e. office space, relocation assistance, etc. Enjoy the support of major West Coast Catholic Hospital System. Community has close proximity to major recreational areas and easy access to Seattle and Portland. For information send CV and references to: Nancy Friedrich, The Friedrich Group, Inc., 9284 Ferncliff N.E., Bainbridge Island, WA 98110.

**FAMILY PRACTITIONER**—South central California, growing, semirural, mountain community. Excellent practice opportunity with supportive medical staff. Contact: Larry Clements, Administrator, Tehachapi Hospital, PO Box 648, Tehachapi, CA 93561; (805) 822-3241.

## Physicians

The Perfect Practice Is  
One That Lets You Practice

At Westworld Community Healthcare, Inc., physicians have something very special: **Time.** Time to devote to their practices, and to their patients. And they have the time because we handle all the business details their practices demand.

The goal of every Westworld Hospital is to help our physicians be as productive as they can possibly be. We handle all the paperwork and administrative details, and assist in everything from setting up medical offices to providing staffing and equipment. What's more, we provide an excellent compensation package - competitive with private practice - along with incentive for additional income. And since our commitment is to meet the unique health care needs of rural America, there is no competing with hundreds of other practitioners for patients.

All of these advantages mean **security** for the Westworld physician. If your commitment is to the highest standards in patient care, and if a rural environment sounds inviting to you, investigate Westworld Community Healthcare. We have a variety of attractive practice opportunities in rural America. Call collect now for more information, or send your curriculum vitae to: **Mr. Joel Feinstein, Dept. PH-3, (714) 768-2981, Westworld Community Healthcare, Inc. 23832 Rockfield Rd., Lake Forest, CA 92630-2880.** We are an equal opportunity employer m/f.

**WCH Westworld Community Healthcare, Inc.**

## PHYSICIAN WANTED

**INTERNIST**—Urgently needed in Ketchum/Sun Valley multispecialty clinic. Will assume large practice of retiring internist. Excellent climate, unlimited recreation facilities and very good schools. Income dependent on productivity. Dr. Bryan Stone, PO Box 2198, Ketchum, ID 83340; (208) 726-9361.

**CALIFORNIA**—Board certified/qualified family practitioner wanted to join satellite clinic associated with 300 physician multispecialty group. Competitive salary and excellent fringe benefits. Ninety miles from Sierra skiing and San Francisco. California license required. Send curriculum vitae to: Dale Robbins, MD, The Permanente Medical Group, Inc., 1001 Riverside Ave., Roseville, CA 95678. An Equal Opportunity Employer.

**FAMILY PHYSICIAN**—Board certified or eligible to join the Family Practice Department of a busy, primary care based multispecialty group. Excellent opportunity for growth. Contact Shane Spray, Administrator, Skagit Valley Medical Center, 1400 E. Kincaid, Mt. Vernon, WA 98273; (206) 428-2524.

## SOUTHERN CALIFORNIA

Prestigious HMO is seeking experienced specialists and general practitioners for our facilities in Los Angeles and Orange Counties. Located in close proximity to major teaching centers, we offer the opportunity for continued professional development and rewarding clinical practice. Excellent compensation and benefits including paid malpractice, life, disability, medical and dental coverage, paid vacations, sick leave, educational leave and retirement plan. Please send CV to: Director/Physician Recruitment, CIGNA Healthplans of California, 700 North Brand Blvd., Suite 500-49, Glendale, CA 91203.

**VERY ACTIVE, MIDDLE-AGED RADIOLOGIST;** 30 years experience, the last 15 doing General Radiology; recent ultra-sound experience of at least one year. Desirous of relocating in a more challenging setting. Group or small hospital practice preferred. Licensed in CA, AZ and WA; CA preferred. Reply Box 7002, Western Journal of Medicine, 44 Gough St., San Francisco, CA 94103.

**UROLOGIST.** Seventeen years solo practice in same location. Boards and FACS. Wishes relocation to SW, W, NW. All practice arrangements considered. CV on request. Box 7009, Western Journal of Medicine, 44 Gough St., San Francisco, CA 94103.

**BOARD CERTIFIED DIAGNOSTIC RADIOLOGIST.** Extensive hospital and office experience, including US, NM, CT and Mammography. Interested in Locum Tenens with possible permanent association. Prefer Bay Area. Call (209) 439-7617 or write Box 7010, The Western Journal of Medicine, 44 Gough St., San Francisco, CA 94103.

**MEDICAL OFFICE, SANTA ROSA.** Fully equipped, furnished (mostly new furniture), computer system, telephone system. Good parking and access. Approximately 1,800 square feet. Over three years left on full service lease. Terms negotiable. (707) 527-0610. Box 2887, Santa Rosa, CA 95405.

**SONOMA, CALIF.**—One 840 square foot and one 1,260 square foot medical suite available for immediate short or long term lease. Located in a well appointed small medical/dental complex one half block from Sonoma Valley Community Hospital. Call (707) 938-5885 or write to Sonoma Medical Center, 357 Perkins Street, Sonoma, CA 95476.

**WANTED: MDs FOR MODERN MEDICAL SUITES.** Prime San Leandro location, Estudillo and Bancroft. Ample parking, bus stop in front, near hospitals. Need GPs, Internists, Radiologists, etc. to complement Dermatology, ENT, OB-GYN and Pediatric practices. Rent: 85c/square foot/month. Full service. Kerry & Associates, Realtors, 151 Callan Ave., San Leandro, CA 94577; (415) 483-4211.

(Continued on Page 884)



#### PRACTICES AVAILABLE

**CALIFORNIA:** Urology, Surgery, Allergy, Orthopedics, Pediatrics, Internal, Family, OB-GYN, Otolaryngology, others. Contact Mary Bradshaw, Practice Broker/Recruiter, 21 Altamont Dr., Orinda, CA 94563, (415) 376-0762.

**GREAT LAS VEGAS** general practice for sale. \$200,000 plus on a four-day work week. Terms. Please reply Box 42100, Las Vegas, NV 89116.

**ESTABLISHED NEPHROLOGY PRACTICE** for sale. Prime location one hour from San Francisco. Dialysis, hypertension, some internal medicine, good coverage. Leaving area. Reply Box 7008, Western Journal of Medicine, 44 Gough St., San Francisco, CA 94103.

**PEDIATRIC PRACTICE—SEATTLE.** Own your own practice in premier group. Excellent income. Available late 1986. Confidence assured. Send CV to Box 7011, Western Journal of Medicine, 44 Gough St., San Francisco, CA 94103.

**FOR SALE:** Pediatric Practice, suburban San Francisco area, busy two doctor office; established over 35 years. Both partners retiring. Will introduce. TERMS. Contact Jack W. Singleton, MD, 20094 Mission Blvd., Hayward, CA 94541; (415) 276-2244.

**INTERNAL MEDICINE PRACTICE**—Immediate sale, San Jose, California; grossing \$150K plus, and still growing; shared lab; hospital next door; asking \$75K. Write Suite 207, 175 N. Jackson Ave., San Jose, CA 95116; (408) 923-3138.

#### OFFICE TO SHARE

**ELEGANT PLASTIC SURGERY SUITE** to share 3,600 square feet, two fully equipped operating rooms, recovery and consultation rooms. Suitable for Plastic Surgeon or any surgical specialty. Contact: Raj Kanodia, MD, 1 (213) 276-3106; 9201 Sunset Blvd., Ste. 405, Los Angeles, CA 90069. Available February 1986.

#### RELEASATE

**CARMEL VALLEY**, 1,000 square feet free standing building with parking. Suitable for family practice. Ready to occupy. Contact Carmel Associates, Box 3262, Carmel, CA 93921.

#### IMPROVED EQUIPMENT

**FOR SALE**—Used medical equipment. Excellent condition. Exam tables, instrument cabinet, small refrigerator, instruments, etc. Doctor retiring. (707) 542-7916.

#### LEGAL COUNSEL

# BMQA

Former Deputy Atty General representing BMQA & Dept. of Health. Now specializing in BMQA investigations and disciplinary actions. Hospital Staff Privilege cases and Defense Malpractice cases thruout Calif.

LAW OFFICES OF SAMUEL E. SPITAL, A PROFESSIONAL CORP.  
1200 THIRD AVE., SUITE 1524, SAN DIEGO, CA 92101 (619) 231-4848

#### LOCUM TENENS SERVICE

##### WESTERN PHYSICIANS REGISTRY

... offers coverage for vacation or continuing education. To arrange coverage for your practice or to participate as temporary physician, contact: Carol Sweig, Director, 1315 Evans Avenue, San Francisco, CA 94124; (415) 826-7676.

#### PHYSICIAN ASSISTANTS

**PHYSICIAN ASSISTANTS**—The California Academy of Physician Assistants maintains a free job listing for its members and prospective employers. For further information, call (213) 402-0441 or write the California Academy of Physician Assistants, PO Box 403, Norwalk, CA 90651-0403.

#### SERVICES

**IF YOU ARE** setting up a new medical practice or need help with your existing practice, please call Kate North/Medical Office Consultant, (206) 823-5639.

**DOCTORS:** Your own laboratory in your office. Initial Lab Set Up, Lab Expansion, Training, Profit Improvement and Personalized to your office needs. JC Clinical Systems, North Hollywood, CA; (818) 508-9150.

#### SNOWBIRD CONFERENCES

Sponsored by  
University of Utah School of Medicine

March 3-7, 1986

##### ADVANCES IN INTERNAL MEDICINE

\$280 fee, CME Credit Offered

March 10-14, 1986

##### MEDICAL AND SURGICAL ADVANCES IN GASTROENTEROLOGY

\$280 fee, CME Credit Offered

#### PARK CITY CONFERENCE

March 17-21, 1986

##### NUTRITION IN CONTEMPORARY MEDICINE

\$275 fee, CME Credit Offered

Information/Registration:

Jennifer Fossum  
Division of Gastroenterology  
University Medical Center  
Salt Lake City, UT 84132  
(801) 581-3581

#### SERVICES

**THE WESTERN CONFERENCE ON ALCOHOL AND DRUG ABUSE** will be held March 19-23, 1986, at the Hyatt Regency Hotel, Vancouver, British Columbia. It is sponsored by WESCAD Management Inc., and co-sponsored by the American Medical Society on Alcoholism and Other Drug Dependencies Inc. The CFPC, AAFP and AMSAODD have each approved CME study credit hours totaling 17, plus 2 for each Workshop attended. Write or call for Conference brochure: WESCAD Management Inc., 3075 Point Grey Rd., Vancouver, B.C., Canada V6K 1A7; (604) 734-7812.

#### COLORADO—SKI AND MEET

in Snowmass Village resort, January 18 to 25, 1986 for a LOW BACK PAIN seminar. "A positive and aggressive approach to Conservative Care" Category #1—20 hours. For information and registration, please contact "LOW BACK PAIN," PO Box 5599, Snowmass Village, CO 81615 or 1 (800) 542-5428.

#### TALK TO PATIENTS IN EVERYDAY SPANISH!

- "Mexican Spanish Pronunciation/Make Friends" cassette & manual: \$13.95 (SATISFACTION GUARANTEED)
  - Other cassettes, full tape courses, including course in **MEDICAL SPANISH**
  - INTENSIVE COURSES IN SUNNY BAJA CALIFORNIA—Weekday, weekend & evening classes—minutes from San Diego
  - CEU's: Calif. BRN #06235
- Call or write for **FREE BROCHURES** today:



CALIFORNIA SPANISH LANGUAGE ASSOCIATION  
189-J Correo Fronterizo, San Ysidro, CA 92073  
(619) 544-0548

#### CMA & CHA PRESENT THE 1986 NEONATAL BRAIN INJURY PREVENTION CONFERENCE

JANUARY 8  
San Diego  
Town & Country  
Hotel

JANUARY 10  
Los Angeles  
County Medical  
Society

JANUARY 11  
San Francisco  
Airport Amfac  
Hotel

\$75 registration fee includes continental breakfast and lunch. 5 hours of Category One credit.

CONTACT  
Janice Rigney  
California Medical  
Association  
(415) 863-5522  
ext. 416

## PHYSICIANS

California (Oakland & Berkeley)  
Board certified/eligible Urgent Care  
Physicians wanted to staff evening  
and weekend Urgent Care of  
expanding H.M.O.; two half-time  
persons preferred; competitive salary  
and superb fringe benefits with  
young, progressive medical group.

Please send CV to **Director of  
Human Resources, Health-  
America, 828 San Pablo Avenue,  
Albany, CA 94706.**

## HealthAmerica

We're making Health care in America Better

EOE M/F



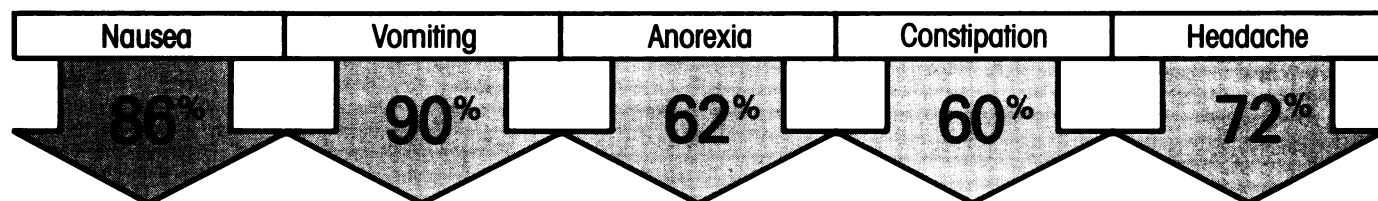
In moderate depression and anxiety

# FEELING BETTER FASTER...

## OVERNIGHT—SLEEP IMPROVED<sup>1</sup>

Sleep improved in 74% after only one h.s. dose in selected patients

## FIRST WEEK—OTHER SOMATIC SYMPTOMS MARKEDLY REDUCED<sup>1</sup>



## FOURTH WEEK—PATIENT COMPLIANCE WAS BETTER<sup>2</sup>

More than three times as many amitriptyline patients as Limbitrol patients dropped out of therapy because of side effects, although the incidence of side effects was similar. Caution patients against the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to lowest effective amount in elderly patients.

**References:** 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner JP, et al: *Psychopharmacology* 61:217-225, Mar 22, 1979.

**Limbitrol<sup>®</sup>**  
Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) <sup>(IV)</sup>

**Limbitrol<sup>®</sup> DS**  
Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) <sup>(IV)</sup>

**A brighter perspective... sooner**

### Limbitrol<sup>®</sup> @ Tranquilizer-Antidepressant

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Relief of moderate to severe depression associated with moderate to severe anxiety.  
**Contraindications:** Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

**Warnings:** Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

**Usage in Pregnancy:** Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

**Precautions:** Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

**Adverse Reactions:** Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

**Cardiovascular:** Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

**Psychiatric:** Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

**Neurologic:** Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

**Anticholinergic:** Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

**Allergic:** Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

**Hematologic:** Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

**Gastrointestinal:** Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

**Endocrine:** Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.

**Other:** Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

**Overdosage:** Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

**Dosage:** Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.

**How Supplied:** Double strength (DS) Tablets, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and Tablets, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt). Available in bottles of 100 and 500; Tel-E-Dose<sup>®</sup> packages of 100; Prescription Paks of 50.



ROCHE PRODUCTS INC.  
Mantolí, Puerto Rico 00701

In depression and anxiety

CLEARING  
SYMPTOM  
FASTER...



3 1496 00278 7813

Limbitrol<sup>®</sup>

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) <sup>(N)</sup>

Limbitrol DS<sup>®</sup>

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) <sup>(N)</sup>

Once daily h.s. for improved compliance 147

Please see reverse side for references and summary of product information.



Copyright © 1986 by Roche Products Inc. All rights reserved.